February 18, 2026

Submitted electronically via regulations.gov

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Transparency in Coverage CMS-9882-P [RIN 0938-AV64]

Dear Administrator Oz:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to provide feedback on the proposed rule *Transparency in Coverage*, regarding price transparency reporting requirements for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage. AANA makes the following comments and requests:

- Ensure that the validation process for determining claims exclusions is vetted by advanced practice provider organizations.

AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 69,000 CRNAs and SRNAs, representing about 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who are autonomous anesthesia providers with extensive education and clinical training, and personally administer more than 58.5 million anesthetics to patients each year in the United States. For further information, see: https://www.aana.com/about-us.

Ensure that the Validation Process for Determining Claims Exclusions Allows for Vetting by Advanced Practice Provider Organizations

AANA appreciates the Centers for Medicare & Medicaid Services' (CMS) continued efforts to improve the standardization, accuracy, and accessibility of public pricing disclosures to promote universal access to clear and accurate healthcare prices. As CMS works towards this goal, AANA has serious concerns about the use of the National Uniform Claim Committee (NUCC)

taxonomy codes and the proposal to "exclude any provider and their negotiated rate (provider-rate combination) for an item or service if the provider is unlikely to be reimbursed for the item or service given that provider's area of specialty, according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process".

We urge CMS to engage advanced practice provider organizations, including the AANA, in reviewing and validating the process used to determine which services are excluded for their respective specialties. We are specifically concerned that this process will be used by insurers as a justification to improperly deny claims for the provision of services that fall within a CRNA's lawful scope of practice[1] but are not captured by National Uniform Claim Committee (NUCC) taxonomy codes. We are likewise concerned that payers could abuse this process to deny network inclusion of CRNAs providing pain management services by citing, "taxonomy misalignment". Also, different plans could map the same specialty to different proxy taxonomy codes which would result in variable reimbursement outcomes for identical services and increased administrative burden due to conflicting payer-specific logic.

The NUCC taxonomy code set is not an accurate reflection of provider scope of practice and should not be used to determine what services are within a provider's scope of practice. While practitioners can self-select taxonomy codes, the codes themselves do not necessarily capture the depth of a provider's specialization. The American Medical Association hosts the NUCC itself, while the rest of the committee is heavily oriented toward physician and commercial payer perspectives and does not include any representation from nursing organizations.

Furthermore, while advanced practice provider organizations can apply for code updates and edits, the process does not allow advanced practice provider organizations to directly have a say in whether those requests are approved. Also, many NUCC taxonomy codes have not been updated since the early 2000s and do not reflect the evolution of practice or emerging models of care. As a result, overreliance on taxonomy codes as an exclusion criterion risks omitting valid provider–service relationships and undermining the completeness and accuracy of reported data.

Specifically, the CRNA taxonomy code (367500000X) has not been updated since April 2002, despite prompting by AANA;[2] the NUCC has denied AANA's application to include pain management as a subgroup under the CRNA taxonomy code on the basis that "no payer organization members of the NUCC supported a need for this taxonomy code". This assertion runs counter to the fact that CRNAs routinely provide pain management services within their

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[1] American Association of Nurse Anesthesiology. Scope of Nurse Anesthesia Practice, available at: https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU.
[2] National Uniform Claim Committee. (2024, January). Health Care Provider Taxonomy Version 24.0. American Medical Association. https://www.nucc.org/images/stories/PDF/taxonomy_24_0.pdf

scope of practice;[3] in fact, CRNAs who provide pain management services have served as subject-matter experts for CMS panels.[4] In effect, the NUCC's decision not to update the CRNA taxonomy code to include pain management services limits CRNAs' scope of practice when plans and issuers are required to rely on provider taxonomy codes as part of their claims adjudication mechanisms for reporting purposes. The NUCC plainly does not possess this authority and should not be able to effectuate it as such.

In fact, CMS has already acknowledged that not all payers, particularly state Medicaid programs, use the NUCC provider taxonomy in their provider credentialing process. As such, the relationship between a provider and their taxonomy(s) will not always be available. CMS uses Transformed Medicaid Statistical Information System (T-MSIS) provider classification as an alternative means for identifying provider specialization. Furthermore, CMS notes that the National Plan and Provider Enumeration System (NPPES) does not verify the accuracy of NUCC taxonomy codes and does not monitor changes in a given provider's specialization over time.[5] Since NPPES does not independently validate whether these codes fully reflect evolving scopes of practice or emerging models of care, when taxonomy codes are outdated, incomplete, or narrowly defined, providers like CRNAs are unable to accurately reflect the services they furnish in their NPI records. This limitation creates negative downstream consequences, affecting claims adjudication, network design, reimbursement determinations, and critically, price transparency reporting when plans rely on NPPES-linked taxonomy data as a filtering or exclusion mechanism.

In response to CMS' request for comment on the Taxonomy File proposal, AANA would urge CMS to provide a transparent and delineated claims adjudication vetting process to meet the requirement at 26 CFR § 54.9815-2715A3(b)(1)(i)(F), which directs plans and issuers to exclude any provider and their negotiated rate (provider–rate combination) for an item or service when the provider is unlikely to be reimbursed for that item or service given the provider's area of specialty, from In-network Rate Files.

AANA understands that the proposed reliance on provider taxonomy codes to exclude provider–rate combinations unlikely to result in reimbursement is intended to reduce unnecessary data, limit file size inflation, and improve the usability and accessibility of In-network Rate Files.

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[3] American Association of Nurse Anesthesiology. (2025, February). Chronic Pain Management Guidelines (page 3). https://issuu.com/aanapublishing/docs/2_-_chronic_pain_management_guidelines?fr=sZDgxODU2NDAxMjU

[4] See for example https://cgsmedicare.com/pdf/Multijurisdictional_CAC_Facet_Joint_and_Medial_Nerve_Branch_Procedures_5-28-2020.pdf, https://www.wpsgha.com/uploads/1153c634_ce2a_4e68_97e7_2e6de6cc02ec_04_27_2023_multijurisdictional_cac_transcript_5cc7ddda7c.pdf, and https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf.

[5] Centers for Medicare & Medicaid Services. *CMS Technical Instructions: Provider Classification Requirements in T-MSIS.* Medicaid.gov. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/98581

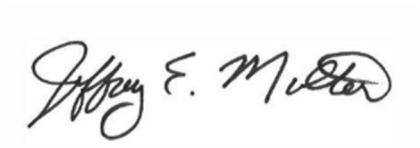
However, because the existing NUCC taxonomy infrastructure does not adequately capture the full scope of services furnished by CRNAs, particularly in the area of pain management, its use for exclusionary purposes would exacerbate existing gaps in transparency data and further obscure CRNA–rate combinations in publicly reported datasets.

Given the absence of statute requiring the use of NUCC taxonomy, AANA urges CMS to consider as an alternative to NUCC provider identification, mechanisms which are more encompassing of the scope of different provider specialties and which account for the evolving nature of health care service delivery. Alternatively, in combination with the use of NUCC taxonomy, CMS may create a mechanism which allows advanced practice provider organizations to vet and validate the services that are being excluded by the process to ensure their accuracy. Plans and issuers would then be required to align their price transparency reporting with these validated services, in conjunction with those determined by NUCC.

Conclusion

We appreciate the opportunity to provide input on the proposed policies in the proposed rule *Transparency in Coverage*. We would welcome the opportunity to meet with you in the coming months to further discuss these issues. Should you have any questions regarding these matters, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,



Jeff Molter, MBA, MSN, CRNA
President, AANA

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Romy Gelb-Zimmer, MPP, AANA Director of Regulatory Affairs
Mosalewa Ani, MPH, AANA Private Payer Analyst